STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175353	A. BUILDING _____ B. WING _____	08/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARMA CARE CENTER LLC	605 EAST MELVIN ST PO BOX 789 ARMA, KS 66712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a health resurvey. A revised copy of deficiencies was electronically sent to the facility on 09/17/13.	F 000		
F 156 SS=E	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during	F 156		9/20/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

The facility must inform each resident of the name, specialty, and way of contacting the

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physician responsible for his or her care.

The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

This REQUIREMENT is not met as evidenced by:
The facility identified a census of 31 residents. Based on record review and interview, the facility failed to provide complete liability and appeal notices to the residents, including 3 residents (# 10, #27, #23) reviewed for liability notices.

Findings included:

- On 08/13/13 at 9:00 AM, review of the liability and appeal notices revealed the following:

1. Resident #10, last date of skilled service date 4/6/13, date of notice 4/3/13.
2. Resident #23, last date of skilled service date not identified on notice, date of notice 4/30/13.
3. An unsampled resident, last date of skilled service date 1/19/13, date of notice 1/16/13.

However, each of these notices lacked the addition of the toll free number for residents or responsible parties to call for appeal or questions, one of the notices, #23, lacked the end of services date noted, and one, #10, lacked a resident signature.

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F 156	Continued From page 3 On 8/13/13 at 10:25 AM, interview with administrative staff C, responsible for the letters, verified that none of the notices given for the last year have the toll free number on them. The facility failed to provide the appropriate liability and appeal notice, including these 3 residents and any other residents that utilized Medicare Services and required the liability notices, to include the phone number to call for appeal or questions.	F 156		
F 159 SS=E	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's	F 159		9/20/13

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behalf.

The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.

The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.

This REQUIREMENT is not met as evidenced by:
The facility had a census of 31 residents and identified 16 with deposited funds accounts handled by the facility. Based on observation, interview and record review, the facility failed to maintain a system that assured a full, complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds including; failure to obtain authorization to handle funds for 1 resident (#37); failure to ensure availability of resident funds when requested for the 16 residents with funds; and failure to provide residents appropriate interest allowed when an unsampled resident's funds account carried a negative balance and 2 other unsampled residents discharged from the facility with zero balances and then accrued

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interest in their accounts.

Findings included:

- On 8/12/13 at 2:10 pm, resident #2 reported, "You have to get the money out before the weekend. Thursday is the last day before the weekend that you can get any money."

On 8/12/13 at 3:22pm, an unsampled resident with a resident funds account reported, "You have to go to the nurses station if it is after hours, but you can't get much, maybe $5 at the most. If you wanted $40, you could not get that."

From 8/12/13 through 8/15/13, signs posted at the east nursing unit and on the business office door documented, "Banking hours Monday through Friday 10 am to 4 pm. For money on weekends, see east nursing station."

On 8/14/13 at 10:00pm, visual examination of the locked resident fund box kept in the east nurse's station medication room, revealed 4 receipts with a total of $10. However, the box lacked any cash on hand for any resident that might request cash. Licensed nursing staff T verified the lack of cash available for the residents. The money box also contained a small clear envelope labeled with $32.00 and the name of resident #37 on the outside. Staff T verified that the money was for that specific resident and not to be used or given to any other residents. Staff T further explained the facility did not hold an actual resident fund account for resident #37.

The facility failed to ensure cash money available for the residents upon request after hours or on weekends.

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On 8/13/14 at 2:00 PM, activity staff E reported the prior business office manager recently left and another facility sent in (business office staff Z), to assist in the resident funds accounts of the facility one to two times per week but reported today as staff Z's third visit to the facility. At that time, staff Z worked in the business office organizing and checking the facility resident funds account information. Staff Z reported at the end of the day, the staff would print off a list of residents the facility held funds for, with a notebook of authorizations and account logs for each resident.

On 8/14/13, review of this current balance report for the residents with trust accounts, provided from staff Z, revealed;

1.) An unsampled resident with a negative balance of $9.00.

2.) An unsampled resident that discharged on 7/9/11, that had expired.

3.) An unsampled resident that had moved to another facility on 5/2/11 and since expired. The facility had returned the residents the money in their accounts after discharge. However, the facility balance log held $.01 for each of these 2 last residents. After discharge the facility inaccurate accounting principles documented the continued gain of interest of $.01.

On 8/15/13 at 1:30 pm, business office staff Z reported, "Parentheses mean it is a negative balance, staff Z verified the negative $9.00 balance of the unsampled resident. Staff Z reported, "Looks like that resident had a hair cut

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F 159	Continued From page 7 on 12/3/12, which created the negative balance. Staff Z further verified the facility held money in the petty cash box for resident #37 without an authorization signed to do so. "We are not to hold any money for them if they do not have the agreement signed." The policy and procedure for deposit of resident funds, revised December 2006, documented, "...file in the resident's financial record a copy of his or her authorization designating the facility as the agency to manage the resident's funds..." The facility failed to handle the residents' funds account in a manner of acceptable accounting principles, as the facility failed to obtain consent to handle funds for 1 resident, failed to provide residents' access to the residents' funds on an ongoing basis, allowed an unsampled resident to have a negative balance, and failed to accurately ensure the 16 residents received the interest appropriately.	F 159		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.	F 225		9/20/13

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The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:
The facility reported a census of 31 residents, with 14 residents sampled. Based on observation, interview, and record review, the facility failed to thoroughly investigate and report to the state agency one (#23), of of the 3 selected residents reviewed for falls.

Findings included:

- The resident's electronic face sheet revealed, resident #23, readmitted to the facility on 7/18/13, with the following diagnoses; debility (feebleness, weakness, or loss of strength), pain, scoliosis

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(lateral curvature of the spine) associated with other condition, osteoporosis (disorder characterized by abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk), and osteoarthrosis (condition of chronic arthritis without inflammation).

The 14 day MDS (minimum data set), dated 7/3/13, revealed the resident had a BIMS (brief interview for mental status) score of 13, indicating intact cognition. The resident required for ADL's (activities of daily living) extensive staff assistance of 1 for transfers, walks in room/corridor, locomotion on/off unit. The resident's balance not steady, and functional limitation in range of motion to upper extremity on 1 side. Mobility per wheelchair/walker. The MDS documented the resident with a fall since admission/entry or reentry or the prior assessment, with 1 major injury.

The Fall Assessment, dated 6/19/13 had a score of 14, a score of 10 or more represents HIGH RISK and needs to be care planned.

The care plan reviewed last on 8/15/13, documented the following:
"--Keep bed in lowest position with brakes locked.
--Keep call light in reach at all times.
--Keep personal items and frequently used items within reach.
--Leave night light on in room above bed.
--7/16/13-Fall-Utilize personal alarm while in residents room for increased alert of staff."

The electronic progress notes, dated 7/16/13 at 2:00 PM, documented the following, "CNA [certified nurses aide] called this RN [registered nurse] to resident's room. Resident was noted to

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be on the floor on [his/her] back. Complaining of left hip pain upon active and passive ROM [range of motion]. Doctor notified. Received order to send to hospital ER [emergency room] for evaluation, ... EMS [emergency medical services], notified." The progress note lacked any further information regarding the fall as witnessed or not.

The electronic progress notes, dated 7/18/13, untimed, documented, "Resident readmitted from hospital, diagnoses of pelvic fracture, arrived via company van, at noon with [Activities/Social services staff D]."

Observation, on 8/12/13 at 11:50 AM, revealed the resident had personal alarm in place, and call light in reach.

On 8/19/13 at 7:45 AM, the resident sitting at the table in his/her room, feeding self breakfast. Reports breakfast is good. The residents personal alarm not in place.

On 8/19/13 at 11:30 AM, the resident ambulating with roller walker in the hall with consultant staff V. The resident's gait is steady. Consultant staff V reported, "The resident did not have a personal alarm on when [the staff] stood the resident up from the recliner."

Interview, on 8/14/13 at 8:42 AM, direct care staff R reported, "We leave the door open. Before the last fall, the resident was pretty independent, would need to remind the resident to use [his/her] call light. The resident fractured [his/her] pelvis. The resident has body alarm and we are to leave the door open."

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On 8/14/13 at 4:42 PM direct care staff O reported, "We take the resident to the bathroom, and dress [him/her]. Since the resident fell and cracked [his/her] pelvis, we started having to do every thing for [him/her] except feed [him/her]. As soon as the resident fell they put the monitor on."

On 8/14/13 at 2:15 PM, administrative nursing staff C reported, "The resident had a fall and went to the hospital. We did not do an Unusual Occurrence Form when this happened. I put an intervention in the care plan."

On 8/15/13 at 9:35 AM, administrative nursing staff B reported, "The resident fall was observed, that was why I did not report it. The administrator does the investigations."

On 8/19/13 at 7:45 AM, direct care staff Q reported, "The resident does not have a personal alarm any more."

On 8/19/13 at :46 AM, administrative nursing staff B reported, "The resident's personal alarm taken off. The resident said he/she would use the call light and not get up on his/her own."

On 8/19/13 at 7:47 AM, the resident sitting at the table in room, eating breakfast. The resident reported, "I told the girls I would use my call light."

The facility's undated Abuse-Allegation and Reporting Policy and Procedure documented, "1. The facility must ensure that all alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property, are reported immediately to the Administrator. If the Administrator is absent, to his/her designee of the

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F 225	Continued From page 12 facility and to other officials in accordance with State Law through established procedures (including to the State survey and certification agency). 2. The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. 3. The results of all investigations must be reported to the Administrator or his/her designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident. If the alleged violation is verified by the Administrative Team, appropriate corrective action must be taken." The facility failed to thoroughly investigate and report to the State agency, as required and per the facility's policy, the resident's fall with injury of a fractured pelvis.	F 225		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: The facility reported a census of 31 residents. Based on observation and interview, the facility failed to provide housekeeping and maintenance services on 2 of 2 hallways for the residents of the facility.	F 253		9/20/13

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Findings included:

- On 8/15/13 at 10:30 AM, during the environmental tour of the facility, the following resident areas revealed the need of housekeeping and maintenance services as follows:

Resident rooms on the west hallway:

1.) One resident bathroom, contained a layer of grime build-up, on the grab bar, next to the toilet.

2.) One resident bathroom, contained floor tiles around the toilet base with gaps between them of approximately 1/8 inch, and a black substance in the gaps.

3.) One resident bathroom, contained a 2 foot area of the base board, loosened from the wall, by approximately 1-2 inches.

4.) One resident bathroom, contained a faucet with the chrome finish peeling off.

5.) One resident room, contained the following: 1.) The corner by the bathroom door had several gouges, approximately 1- 2 inches in length. Also missing a top layer of sheet rock approximately 6 inches by 4 inches. 2.) The bathroom door: approximately 2 feet up from the bottom of the door, had 2 holes, measuring approximately 2.5 inches in diameter. Also had scratches 2 feet up from the bottom of the door, measuring 2 feet in length by 2 inches in width and 1 foot by 2 inches. 3.) The bathroom door frame with numerous scratches from the base to approximately 2 feet

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up. 4.) The window blinds missing four slats. The four slats lying on the window sill.

6.) One resident bathroom, contained floor tiles, around the toilet base, with approximately 1/8 inch gaps between them and a black substance in the gaps.

7.) The soiled utility room contained 5 missing tiles on the wall, the floor tiles with a 1/8 inch gap showing a black substance. The counter top with a yellow discoloration. The faucet and sink had green discoloration.

8.) The resident shower room contained the following: 1.)The sink drained very slowly. The faucet on the sink had a reddish discoloration. 2.) The tile floor, where meets the vinyl floor, had a 1/2 inch layer of dark brown substance. The tiles in the bathing area had a layer of grime. 3.) The wall below the soap dispenser had a sticky substance on it.

9.) At the end of the north hall, a glass window had an approximate 6 inch crack, with a 1/2 inch star type crack in the center.

Resident rooms on the east hallway:

1.) One resident bathroom wall, below the soap dispenser, contained a sticky substance.

2.) One resident bathroom, contained vinyl flooring with a gray discoloration, measuring approximately 1 foot by 1 foot.

3.) One resident bathroom contained 2 shelves made of raw particle board, approximately 2 feet by 1 foot, not a cleanable surface.

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4.) One resident bathroom door frames, at the base, contained reddish discoloration.

5.) One resident bathroom contained vinyl flooring with a tan discoloration, and the door frame had a reddish discoloration at the base.

6.) One resident room contained the following: 1.) The front of a dresser drawer contained numerous 1 inch gouges. 2.) One the wall behind the bed, had two, 2 inch indention's. 3.) On the wall behind the bedside table, 2 indention's in the sheet rock measuring approximately 2 inches by 2 inch, and also missing the top layer of sheet rock measuring approximately 6 inches by 4 inches. 4.) On the wall behind the recliner, 2 indention's in the sheet rock measuring approximately 2 inches by 1 inch.

7.) The resident shower room contained approximately a 4 inch by 2 inch piece of sheet rock missing at the base of the entrance into the shower area, and the sink with a greenish discoloration.

The facility main dining room.

1.) The white pillars in the dining room, contained a layer of grime, from approximately the floor to 6 inches up.

2.) The counter contained a white discoloration and the sink in the dining room contained a white build up. The cabinet doors marred.

3.) The door to the patio, lacked paint appropriately 1 inch by 4 inch's around the the door handle.

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F 253	Continued From page 16 4.) The wall south of the door, contained scratches across the wall, approximately 3 inches by 1 inch. The dining room floor, around the edges contained a layer of grime, measuring approximately 1 inch. The medication room nutrition refrigerator on tour had a layer of ice, approximately 3 inches thick, in the freezer. The floor contained small debris on it, unswept and a layer of grime, approximately 1 inch around the edges. The counter contained a yellow discoloration, approximately 8 inches diameter, and under the wall soap dispenser. The sink (stainless steel) contained a white film around it, with black areas near the drains. The entire room had a soiled and cluttered appearance. Interview, on 8/15/13 at 11:30 AM, housekeeping/maintenance staff G reported, "All these areas have been QA'd [Quality Assurance]." The facility failed to ensure appropriate housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior in these resident areas.	F 253		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the	F 274		9/20/13

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resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)

This REQUIREMENT is not met as evidenced by:
The facility reported a census of 31 residents, with 14 residents sampled. Based on observation, interview, and record review, the facility failed to do a significant change MDS (minimum data set) for one sampled resident (#37).

Findings included:

- Review of resident #37 electronic face sheet revealed the resident readmitted to the facility on 6/23/13, with the following diagnosis;diabetes mellitus (when the body can't use glucose, there's not enough insulin made or the body can't respond to the insulin), End Stage Renal Disease (a disease condition that is terminal because of irreversible damage to vital tissues or organs), and traumatic brain injury (injury to to brain involving trauma).

The admission MDS (minimum data set), dated 3/1/13, revealed the resident had a BIMS (brief interview for mental status) score of 1 out of 15, indicating severely impaired cognition. The resident required extensive staff assistance of 1 for transfer and toilet use; and supervision and 1

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staff assistance for eating. The resident continent of bowel and bladder. No infection. The resident did not have any swallowing issues, weight 130 pounds, and received a mechanically altered/therapeutic diet. The resident received insulin, antipsychotic, antianxiety medication and Dialysis services.

The quarterly MDS 3.0 dated 5/31/13, revealed the resident had a BIMS score of 15, indicating intact cognition. (The resident changed from severely impaired cognition to intact cognition) The resident required extensive staff assistance of 1 for transfer and toilet use, and set up/supervision for eating (The resident improved and does not need assistance eating, only supervision). The resident had a diagnoses of Multidrug Resistant Organism (MDRO), wound Infection (other than to foot). (The previous MDS, the resident did not have an infection). The resident had loss of liquids/solids from mouth when eating or drinking, and coughing or choking during meals or when swallowing medications. (The previous MDS, the resident did not have any swallowing issues). The resident weighed 114 pounds, had weight loss and not on a physician prescribed weight loss regimen. (The resident lost 20 pounds from 134 pounds to 114 pounds, since the prior assessment). The resident received insulin, Dialysis and received speech therapy for 120 minutes for 2 days, start date of 5/7/13.

This assessment revealed significant change in the resident cognitive status from severe to intact; a severe weight loss of 20 pounds; and improvement in eating, but with swallowing problems.

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F 274	Continued From page 19 Observation, on 8/14/13 at 2:35 PM, revealed the resident in a recliner in the room with the television on. The resident wore a loose fitting sweater. The facility staff failed to complete a significant change assessment for this dependent resident, who experienced multiple changes in mental and physical ability.	F 274		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: The facility identified a census of 31 residents, with 14 residents sampled. Based on observation,	F 279		9/20/13

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record review and staff interview, the facility failed to develop a comprehensive care plan for 1 sampled resident (#33) for infection.

Findings included:

- The face sheet in electronic medical records revealed resident # 33 , admitted to the facility on 11/2/11, with diagnoses including; Pressure ulcer stage IV, history of venous thrombosis (presence of a clot in a vein), UTI (urinary tract infection), and bacterial infection.

The quarterly MDS (minimum data set) assessment, dated 6/21/13, revealed the resident with a BIMS (brief interview for mental status) score of 14, indicating cognitively intact. ADL's (activities of daily living): Extensive assist in bed mobility, transfers, locomotion on/off unit, dressing, toileting, personal hygiene. Pain- receives scheduled pain med regimen. Rarely experiences mild pain. Height 65, weight 205. on a physician prescribed weight gain regimen. Skin: Stage IV Coccyx measurement 5 cm x 4.5 cm x 4.5 cm with granulation tissue.

The CAAS (care area assessment summary), dated 11/8/12 , revealed:
"...Has indwelling Foley catheter to promote wound healing to stage IV pressure ulcer on coccyx...has stage 4 pressure ulcer,...Pressure Ulcer- resident has stage IV pressure ulcer to coccyx, is at risk for pressure ulcers, at risk for infection...Foley Catheter inserted to promote wound healing."

The most recent care plan, undated, lacked any intervention related to infections for this resident related to the resident's pressure ulcers/wounds.

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On 8/15/13 at 8:10 AM, the resident stated, "Aware that my leg had an infection a while back. The nurse here and the wound care clinic people had talked to me about it. They were putting cream on it to clear it up, I don't think it's a problem anymore, it seemed to have worked."

Interview with licensed nursing staff I on 8/14/13 at 7:35 AM, reported, "When we have a resident with an infection, we do the Infection report every shift for the length of the antibiotic treatment, then for 3 days follow up for adverse reaction. The CNA's (certified nursing assistants) get in report what they are supposed to be looking for..."

Interview with administrative staff C on 8/19/13 at 1145 AM, staff stated, "We don't implement a care plan with infections. We just fill out the resident infection report until the antibiotic is complete. It has interventions that can be checked for infection, but it's not a care plan. Also, because the nurse is filling out that report, they are not making a nurses note about the infection."

Interview with administrative staff B on 8/19/13 at 11:50 AM, reported, "Sometimes when a resident has an infection, we write that in somewhere on a the current list of care plans, then highlight it and mark it as resolved when the antibiotic is complete, but we actually don't have any official care plans for infections. We have used a temporary one in the past that is a generic cover all types of infection type care plan, and I have pulled those out..."

Physician Order, dated 3/29/13, documented, "Cleanse right lower extremity with wound

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F 279	Continued From page 22 cleanser, apply Bactroban to affected area and cover with 4 x 4 and wrap with Kerlix until healed." A Resident Infection Report, dated March, 2013, documented: "Diagnosis: Wound Culture Treatment: Bactrim DS BID x 14 days. Summary of Daily sheets, dated 3/29/13 - 4/14/13 and report every shift of daily care with treatment, dressing changes through completion of antibiotic." The facility failed to develop a comprehensive care plan for infections for this resident with wounds and reported infections.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280		9/20/13

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This REQUIREMENT is not met as evidenced by:
The facility had a census of 31 resident, with 14 sampled for review. Based on observation, interview, and record review, the facility failed to review and revise the care plans for 3 sampled residents (#6, #4, & #24) for accidents.

Findings included:

- The electronic face sheet, revealed resident #6, readmitted to the facility on 12/3/08, with the following diagnosis; multiple sclerosis (progressive disease of the nerve fibers of the brain and spinal cord), glaucoma (an abnormal condition of elevated pressure within an eye caused by obstruction to the outflow), osteoporosis (disorder characterized by abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk), anxiety disorder (a mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, melancholy, dejection, worthlessness, emptiness and hopelessness), and muscle spasm.

The annual MDS (minimum data set) 3.0 dated 7/5/13, revealed the resident had a BIMS (brief interview for mental status) score of 15, indicating cognition intact. For ADL's (activities of daily living) the resident required limited staff assistance for bed mobility, transfers; and extensive staff assistance for toilet use. Balance is not steady, and had limitation in range of

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motion to upper and lower extremity on both sides. Mobility per wheelchair. Occasionally incontinent of urine and always continent of bowel. No falls documented. The resident received restorative nursing services for transfers 3 days for 15 minutes.

The CAAS (care area assessment summary), dated 7/12/13, revealed for ADL's the following; "Requires assistance with ADL's related to diagnosis of MS (multiple sclerosis). Is at risk for decline in independence with ADL's. Is non ambulatory. Wheels self in wheelchair, limited assist at times for maneuvering through doorways. Has impaired balance during transfers. Has impaired ROM (range of motion) to right lower extremity related to MS..."

The CAAS, dated 7/12/13, for falls, documented the following; "At risk for falls related to impaired balance during transfers, not able to maintain standing balance for longer than a few seconds, impaired ROM to right lower extremities related to MS..."

The Fall Assessment, dated 7/4/13 had a score of 10, with a score of 10 or more represents HIGH RISK for falls and must be care planned.

The care plan reviewed last on 5/31/13, documented the following;

"--Remind the resident to lock wheelchair prior to transfer.
--Restorative nursing program: maintain and improve transfers. Staff assist with transfers and use parallel bars to increase strength and ability to transfers every shift.
--Assist with position changes for comfort as

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needed. Has increased anxiety when clothing or bedding feels restrictive or 'bunches up'.
--Encourage the resident to call for assist with transfers when having periods of weakness due to MS.
--Keep bed in lowest position with brakes locked. Mobile via wheelchair propelled by self. May occasionally require staff to propel.
--Provide toileting assistance as the resident allows, requires reminders to ask for assist with tilting, but allow the resident to toilet self to maintain as much independence as possible.
--Remind me to wear shoes or gripper socks when transferring to assure safe transfers.
Re-educate me in regards to transferring self. Explain the need to use call light to prevent injury and allow staff to be present when transferring. I like to go barefoot and will refuse to wear footwear at times.
--Has transfer pole in room to assist with transfers, Educate the resident on use of pole as needed."

1.)The facility Unusual Occurrence Record, dated 7/30/13, documented the following;
"Resident: Alert and oriented, unattended fall,bruise.
At 8:30 AM, CNA [certified nurses assistance] called this RN [registered nurse] to the bathroom and stated resident was yelling out 'help'. Upon entering, resident was sitting on the floor in front of toilet. Resident stated [he/she] was 'trying' to get to the toilet but didn't make it. Denies pain and denies hitting [his/her head]. Bruise noted to right mid back, 2.5 cm [centimeters] by 4 cm. Bruise to right arm, below elbow, 2.5 cm by 1 cm. New intervention: Placed back into manual wheelchair, due to complication of transferring from scooter.

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F 280	Continued From page 26 The staff continued to document vital signs on resident every 12 hours through 8/1/13 for 6 PM-6 AM. 2.) The facility Unusual Occurrence Record, dated 8/2/13 at 2:00 PM, documented the following: "Smoke Room. Resident alert, injury of hematoma [a collection of blood trapped in the tissues of the skin or in an organ, resulting from trauma]. Resident leaned over in wheelchair to pick up unlit cigarette and fell to the floor. A 3 cm round hematoma over forehead. Ice pack applied to forehead prn [as needed] given for complained of pain. New intervention: Staff to hold cigarettes until they are there to supervise." The staff continued to document vital signs and bruising on resident every 12 hours through 8/4/13 for 6 PM-6 AM.. 3.) The Nurses Progress Notes, dated 8/7/13 at 10:45 AM documented the following: "Called to whirlpool room, resident found sitting against wall in front of toilet. The resident stated that [he/she] was trying to get on the toilet and lost [his/her] balance. Resident states that [he/she] didn't hit head. Vital signs stable, no immediate distress noted. Only complaint of pain is to upper back, underneath right shoulder blades. Small scrape and redness to area underneath right shoulder blade PCP [Primary Care Physician] notified, no new orders, continue to monitor resident, encourage use call light and not transfer without assistance. Resident verbalizes understanding." The facility Unusual Occurrence Record dated 8/7/13, documented the following:	F 280		

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"Whirl pool room. Occurrence Type: unattended Fall. No Apparent Injury.
Resident was transferring self in whirlpool shower room. Resident states [he/she] did not hit [his/her] head. Lost balance and fell with back against wall. Resident denies severe pain. States [he/she] is sore on should blade, and upper back area. Small area reddened underneath right should blade. No other signs or symptoms of distress. Personal Alarm."

The staff continued to document vital signs, pain, and PA through 8/9/13 for 6 PM-6 AM.

Observation, on 8/14/13 at 7:00 AM, revealed the resident resting quietly in bed with eyes closed. bed in the lowest position, and personal alarm in place.

On 8/14/13 at 8:32 AM, the resident sitting on the side of the bed. Direct care staff R encouraged the resident to used the transfer pole. The resident grabbed the transfer pole and staff R assisted the resident to transfer to the manual wheelchair. Staff R then gave the resident [his/her] call light, due to the resident wanting to eat breakfast and have [his/her] bed made, with PA (personal alarm) in place. However, the resident lacked wearing non-skid socks or shoes.

On 8/14/13 at 8:52 AM, the resident transferred, to the toilet with direct care staff U providing standby assistance. The resident grabbed the transfer bar in the bathroom, stood, pivoted and sat on the toilet. After the resident finished toileting, transferred self to manual wheelchair, with direct care staff U providing standby assistance. Personal alarm placed on the resident. The resident continued lack of non-skid

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socks, instead wore regular white socks on.

On 8/14/13 at 9:06 AM, direct care staff Q, assisted the resident to stand, from the manual wheelchair, with gait belt, using the Parallel bars, without non-skid socks.

Interview, on 8/14/13 at 8:35 AM, direct care staff R reported, "The resident has MS, a progressive illness. Up until the last couple of weeks [he/she] had been independent. The resident has a body alarm, one person assist for transfers. I would like to suggest we have a report. Sometimes we do. The nurses are very good about telling us. The body alarm, provides better attention to what [his/her] needs are. The resident will use [his/her] call light. The bed is to be in the lowest position."

On 8/14/13 at 4:45 PM direct care staff O reported, "The resident used to be very independent, does have a tendency to take off, especially if we are busy. Direct care staff O not aware of the resident having a fall in the last 30 days. The staff are to look at the care plans, and to follow the care plans."

On 8/14/13 at 1:45 PM, administrative nursing staff C reported, "When a resident falls, we do an Unusual Occurrence Form, and document on it for 3 days. We do not usually document in the nurses notes about a resident who had a fall. The nurse can update the care plan for a fall if they can decide on an intervention. I just updated the resident's care plan from the Unusual Occurrence Form. Did not realize a new intervention needed to done timely."

On 8/15/13 at 9:20 AM, administrative nursing

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staff B reported, "The CNA's [certified nurses aide] are told the interventions by the nurse and the nurse is to monitor the CNA's to make sure the interventions are being done."

The facility failed to review and revise the residents care plan to include the interventions implemented following each of the resident's last 3 falls from 7/30 to 8/7/13.

- Review of the electronic face sheet for resident #4 revealed the resident admitted to the facility on 9/28/11, with the following diagnoses, Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure).

The quarterly MDS (minimum data set) dated 6/19/13, revealed the resident with a BIMS (brief interview for mental status) score of 0, indicating severely impaired cognition. The resident required extensive staff assistance for bed mobility, transfer, walking, locomotion on/off the unit, and dressing. No falls. At risk for pressure ulcers, pressure reducing device for bed and chair.

The care plan, reviewed last on 9/12/13, documented, "The CNA's (certified nurses aides) to do skin checks 2 times a week on shower days, and to report any issues to the nurse. Nurses do skin assessments weekly. Requires limited assist with bed mobility at times. Requires limited assist with toileting to manage clothing. I have a pressure reduced bed mattress on my bed.
Report any signs of skin breakdown (sore, tender, red or broken areas.) Treat as indicated."

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A weekly skin integrity action tool, dated 8/2/13, revealed, "Skin warm and dry. Healing bruise noted to right side of forehead, measuring approximately 0.7 cm (centimeter) by 2 cm, black and blue in color. No other new skin issues noted."

A weekly skin integrity action tool, dated 8/9/13, revealed, "Skin warm and dry. No new skin issues noted."

Observation on 8/12/12 at 2:14 PM, revealed 3 cm (centimeter) by 3 cm purple discoloration to the resident's left wrist area.

A shower body check form dated 8/13/13, documented, "Bruises noted to left arm and right arm."

An unusual occurrence record, dated 8/14/13 at 8:00 AM, documented: "Found to have a 4 cm by 4.5 cm purple bruise to right forearm, that matches up with arm on wheelchair. Intervention wheelchair arm padded."

On 8/14/13 at 7:21 AM, observation revealed, an unidentified direct care staff applied gait belt to resident and assisted resident from wheelchair to dining room chair. The staff held onto the resident's gait belt during transfer.

On 8/14/13 at 10:53 AM, resident's spouse revealed, "Nope we don't know how [he/she] got a bruise on [his/her] arm. It's been there 2 or 3 days or a week. We thought [he/she] might have bumped it on the wheelchair."

On 8/14/13 at 4:30 PM, direct care staff O

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reported, "The bruise happened on my nights off, when I came back on Friday [8/9/13] the bruise was there. The resident bruises easily. I asked [him/her] what happened and [he/she] didn't know."

On 8/14/13 at 10:55 PM, direct care staff P reported, "I noticed the bruise and reported it to the nurse, but they already knew about it."

On 8/19/13 at 10:47 AM, direct care staff R reported, "I noticed the bruise and reported it to licensed nursing staff I over a week ago, but the nurse already knew about it."

On 8/19/13 at 10:50 AM, direct care staff Q reported, "I noticed the bruise last Tuesday [8/6/13] and told the medication aide but they already knew."

The facility failed to review and revise the care plan timely to include interventions to prevent further bruising to the resident.

- Review of resident #24's electronic face sheet revealed the resident admitted to the facility on 1/15/10 with the following diagnosis; Alzheimer's (progressive mental deterioration characterized by confusion and memory failure), dementia (progressive mental disorder characterized by failing memory, confusion), anxiety state (a mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), delusional disorder (a false belief or wrong judgment, sometimes associated with hallucinations, held with conviction despite evidence to the contrary), chronic pain, and depressive disorder (abnormal emotional state

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characterized by exaggerated feelings of sadness, melancholy, dejection, worthlessness, emptiness and hopelessness).

The quarterly MDS (minimum data set) dated 7/3013, revealed the resident had a BIMS (brief interview for mental status) score of 3, indicating severely impaired cognition. The resident had delusions, and other behavioral symptoms not directed toward other, 4-6 days. The resident required for ADL's (activities of daily living) required limited staff assistance for transfers,and walking. Balance not steady, no impairment in functional range of motion, mobility per wheelchair. Fall since prior assessment two or more, non-injury. The resident received an antipsychotic and antidepressant medication. The resident received restorative nursing for 7 days for walking.

The care plan, reviewed last on 6/6/13, for falls documented, "Observe frequently by staff. Place resident in facility commons area as resident allows while not in bed. Ensure the resident is lying in the middle of the bed or left side of the bed. Ensure footwear daily for resident safety. Update on 7/25/13, Personal alarm to ensure increase alert of staff when the resident attempts to ambulate without assistance."

On 8/13/13 at 4:44 PM, observation revealed the resident rested on the bed with a personal alarm attached. However, the control box lay on the pillow beside the resident and well within the resident's reach.

On 8/13/13 at 4:36 PM, observation revealed, the resident assisted with ambulating in the hallway with unsteady gait by 2 staff and a gait belt on.

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F 280	Continued From page 33 On 8/14/13 at 7:17 AM, observation revealed the resident rested on the bed with the personal alarm attached to the resident. However, the control box lay on the bed next to the resident and unattached to anything else. At that time, direct care staff R assisted the resident into a wheelchair. Direct care staff R then placed a gait belt on th resident and ambulated the resident to the dining room with another CNA following behind with the wheelchair. On 8/14/13 at 8:02 AM, observation revealed the resident in the recliner in ([his/her) room. The personal alarm attached to resident and the control box placed in recliner seat behind resident's back, but within the resident's reach. On 8/14/13 at 8:36 AM, observation revealed the resident resting on the bed. The personal alarm on the resident, but the control box rested on the bed not attached to anything. On 8/14/13 at 9:35 AM, the resident yelled out "help" attempting to sit up on the side of the bed. The alarm attached to the resident but the control box rested on the bed unattached to anything. At 9:38 AM, an unidentified direct care staff assisted the resident to the bathroom. On 8/14/13 at 2:40 PM, observation revealed, the resident stood in the room doorway yelling for help. The resident held the alarm control box in [his/her] hand with the clip attached to the resident and not sounding. Consultant staff S walked by the resident's room, while pushing another resident in a wheelchair, stopped and looked at the resident while the resident yelled for help and then proceeded with the other resident	F 280		

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F 280	Continued From page 34 in the wheelchair to the therapy room. After 4 minutes of the resident yelling for help, another unidentified direct care staff responded to the resident and assisted the resident with needs. Interview, on 8/13/13 at 4:44 PM, direct care staff R reported, "The resident has had the alarm since [his/her] last fall. We can look to see what to do for the resident on our CNA [certified nurses aide] care plans in the ADL book." On 8/14/13 at 4:14 PM, direct care staff reported, "Last week the resident walked in the hall with [his/her] shirt pulled up around [his/her] ears. The alarm was attached to the residents shirt. This is more of an afternoon thing for [him/her] (getting up out of bed)." On 8/14/13 at 4:30 PM, direct care staff O reported, "I don't like the alarm, you can't hear it, they will come undone if the resident barely moves. It doesn't work for the resident, [he/she] needs a pressure mat alarm." On 8/15/13 at 10:20 AM, administrative staff B reported, "To determine if the personal alarm was effective for the resident, would be whether or not the resident had any further falls. Staff B was not aware that the resident ambulated in the hallway with the alarm and acknowledged that it was probably not documented." The facility failed to review and revise the resident's care plan to include an appropriate intervention when the resident removed or carried there personal alarm with them unassisted.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		9/20/13

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Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:
The facility reported a census of 31 residents, with 14 residents sampled. Based on observation, interview, and record review, the facility failed to monitor one sampled resident on dialysis services (#37), with the failure to perform a complete assessment on the resident upon return to the facility from dialysis services.

Findings included:

- Resident #37's electronic face sheet, revealed the resident readmitted to the facility on 6/23/13, with the following diagnoses; end stage renal disease (a disease condition that is terminal because of irreversible damage to vital tissues or organs).

The admission MDS (minimum data set), dated 3/1/13, revealed the resident had a BIMS (brief interview for mental status) score of 1, indicating severely impaired cognition. The resident required extensive staff assistance of 1 for transfer and toilet use. The resident received dialysis services and mechanically altered/therapeutic diet.

The quarterly MDS 3.0 dated 5/31/13, revealed

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the resident had a BIMS score of 15, indicating intact cognition. The resident required extensive staff assistance of 1 for transfer and toilet use, and set up/supervision for eating. The resident had a diagnoses of Multidrug Resistant Organism (MDRO), wound infection (other than to foot), and malnutrition or at risk. The resident had loss of liquids/solids from mouth when eating or drinking, and coughing or choking during meals or when swallowing medications. The resident weighed 114 pounds, had weight loss and not on a physician prescribed weight loss regimen. The resident received dialysis services.

The CAAS (care area assessment summary), dated 3/4/13, revealed for cognitive loss the following: "Resident has cognitive loss and impaired memory recall related to hypoxic brain injury, had been in hospital from beginning of Dec. 2012, until admission to LTCF [long term care facility]. Diagnosis of DMI [diabetes mellitus, insulin dependent], ESRF [end stage renal failure], and thyroid disease."

The care plan reviewed last on 7/3/13, documented the following;
End stage Renal Disease:
--Has dialysis shunt to right upper extremity. Avoid drawing labs, taking blood pressure to right upper extremity. Encourage elevation of right upper extremity.
--Receives dialysis 3 times weekly at local dialysis center. Dialysis communication book is located at nurse's station to be sent with the resident to dialysis appointments.
--Allow resident/family to express feelings, concerns and fears.
--Be available for resident/family.
--Involve resident in care and decision making to

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maximal potential.
--3/31/12-Has unused peritoneal dialysis catheter to LUQ (left upper quadrant).

The care plan lacked monitoring of the resident's dialysis shunt before or after dialysis services provided.

The Hemodialysis Communication book, contained a Hemodialysis Communication Form with an area for the nursing facility staff to document the residents vital signs, medications, and blood sugars, prior to going to dialysis services.

The electronic nurses progress notes from 8/15/13 through 7/1/13, lacked documentation as to the resident's shunt site being checked/assessed before or following dialysis services.

The TAR (treatment administration record) for July 2013 and August 2013, lacked documentation of the resident's shunt site being checked before or after dialysis.

Observation, on 8/14/13 at 2:35 PM, revealed the resident in a recliner in the room with the television on. The resident wore a loose fitting sweater.

On 8/14/13 at 10:12 AM, direct care staff D reported, "The resident receives dialysis 3 times a week, careful of right arm, is weak on [his/her] feet, [he/she] takes thickened liquids, does ok with it."

On 8/14/13 at 4:42 PM direct care staff O reported,"The resident transfers with 1 staff

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F 309	Continued From page 38 assist. Have to keep the resident close to you, because [his/her] gait is unsteady. Have to be careful of right arm." On 8/15/13 at 9:30 AM administrative nursing staff B reported, "We have never had an issue with dialysis. We don't check the shunt site before or after dialysis. If there was any bleeding we would put a pressure dressing on it." On 8/19/13 at 7:30 AM, licensed nursing staff T reported, "I check the shunt site when I work, but I don't document that I do." The Lippincott Manual of Nursing Practice, 8th edition, documented, "Hemodialysis patients...close monitoring...complications of vascular access...including infection, uncontrolled bleeding, clotting of access, hemodynamic status..including edema, fluid intake and output, hypo/hypertension..." The facility failed to monitor the resident upon return to the facility from receiving hemodialysis treatments to ensure no diverse effects to the resident are unnoted.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by:	F 312		9/20/13

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The facility reported a census of 31 residents. The 14 selected residents included 3 reviewed for ADLs (activities of daily living) with personal hygiene. Based on observation, record review, and interview, the facility failed to ensure adequate personal hygiene for 1 (#13) of the 3 selected residents.

Findings include:

- The medical record of resident #13 documented admission to the facility on 1/14/13, with readmission on 3/9/13.

The Quarterly MDS (minimum data set), dated 7/17/13, revealed the resident with severely impaired cognition. It identified the resident required; extensive assist of one staff with dressing, and personal hygiene; extensive assist of two staff with bed mobility; total dependence of one staff for toilet use and locomotion; and total dependence of two staff for transfers. It identified the resident with an indwelling foley catheter and a colostomy.

The care plan dated 5/8/13, instructed staff the resident gets, "Shower 2 times weekly and as needed ...Give bed bath while on bed rest."

The facility's shower body check program sheets, revealed the resident received a bed bath on: 6/26/13, 6/29/13, 7/3/13, 7/6/13, 7/10/13, 7/13/13, 7/17/13, 7/20/13, 7/24/13, 7/27/13, 7/31/13, 8/4/13, 8/8/13, 8/10/13, and 8/14/13.

On 8/12/13 at 11:15 AM, observation revealed the resident lying in bed with greasy appearance, uncombed hair, and in need of shampooing.

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F 312	Continued From page 40 On 8/13/13 at 1:18 PM, a family interview stated, "I have come in to see [the resident] and [the resident] has had food on face and clothing, and has body odor sometimes." On 8/14/13 at 7:15 AM, observation revealed the resident's hair continued with the greasy appearance. On 8/14/13 at 12:23 PM, direct care staff K stated, "I give [the resident] medications, reposition [him/her] and give [him/her] baths. The shower chair is very uncomfortable for [the resident]. Right now [he/she] is on bed rest, so [he/she] gets bed baths." On 8/15/13 at 9:01 AM, administrative nursing staff B stated, "We use the no rinse shampoo on [the resident] since [he/she] can't get out of bed.... I didn't know we were out of the no rinse shampoo. [The resident] usually gets [his/her] bath on the evening shift. Bath/Bed Policy revised 06/2013 lacked a procedure for cleansing residents hair and documented, " ...comb the resident's hair ..." The facility failed to provide adequate personal hygiene for the bed bound resident, to include combing and washing hair.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that	F 314		9/20/13

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they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

This REQUIREMENT is not met as evidenced by:
The facility identified a census of 31 residents. The sample included 14 residents with 3 reviewed for pressure ulcers. Based on observation, record review and staff interview, the facility failed to provide necessary treatment and services to promote healing and prevent infection for 2 (#15 and #13) of the 3 sampled residents with pressure ulcers.

Findings included:

- Review of the electronic record, revealed resident #15 returned to the facility on 5/30/13, with a pressure ulcer to the heel, open wound to the left stump and uncontrolled diabetes type II (when the body can't use glucose, there's not enough insulin made or the body can't respond to the insulin).
The admission MDS (Minimum Data Set) 3.0, dated 6/7/13, revealed the resident with a BIMS (Brief Interview of Mental Status) score of 14 which indicates intact cognition. The resident required extensive assist with two staff assist for bed mobility, transfers, dressing and toilet use. The MDS also revealed an unstageable pressure sore due to slough and/or eschar that was present upon admission. The measurements of the wound with the necrotic tissue measured 4 cm (centimeters) by 5 cm. The resident with a pressure reducing device for the chair and bed, turning and repositioning program, pressure ulcer

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care, application of non-surgical dressings and applications of ointments/medications. The resident received oxygen and IV (intravenous) medications.

The CAAS (Care Area Assessments) for pressure ulcers, dated 6/12/13, revealed, "Resident is at risk for new and worsening of pressure ulcers...Current unstageable pressure to right heel due to coverage of eschar, described as black blister. Other skin issue include wound to left stump caused by fall in hospital resulting in wound dehiscence post amputation as reported by the resident. The resident is receiving consultation and treatment from wound care."

The care plan, dated 6/17/13, directed staff to ensure a pressure reducing device to bed and chair, encourage resident to float heels when in bed and encourage use of heel protectors when in bed, encourage and assist resident to turn and reposition every 1-2 hours and measure and assess wound and skin check every week.

Review of the wound care notes indicated:

1.) On 5/30/13, revealed measurements of the pressure ulcer 4 cm x 5 cm as a black blister.

2.) On 6/28/13, reveal the right heel measurement of 2.7 cm by 2.2 cm and the left stump measurements of 2.7 cm by 1.3 cm by 0.2 cm.

3.) On 7/5/13, reveal the right heel as 3.5 cm by 4.7 cm and the left stump as 2.5 cm by 3.0 cm.

4.) On 7/24/13, the right heel as 2.5 cm by 2 cm by 0.3 cm; left stump as 0.3 cm by 0.3 cm by 0.1

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cm; and a new area to the right medial malleolus as 0.5 cm x 0.5 cm.

5.) On 8/6/13, the right heel as 3.5 cm by 2.8 cm; left stump 0.4 cm by 0.6 cm by 0.1 cm; and the right dorsal great toe as 0.8 cm x 0.7 cm by 0.3 cm with 0.5 cm by 0.5 cm, with moist yellow/tan discoloration with a total circumference of the wound 2.5 cm by 1.2 cm.

A physician order, dated 8/7/13, instructed, Vancomycin 500 mg (milligrams) IV every 12 hours for 10 days, from 8/8/13 through 8/17/13, for infection of the great toe.

Observation, on 8/14/13 at 9:15 am, revealed the resident in the recliner with right heel floating. The right heel dressing with noted light brown drainage approximately 3 cm diameter.

On 8/14/13 at 9:45 am, the resident rested in a recliner, no cushion to the recliner. The right foot floated and a pillow between the seat and the foot rest that LBKA (left below the knee amputation) rested on.

On 8/14/13 at 3:dpm, resident back in the recliner with right heel floating, a pillow between the seat and the foot rest and no cushion. A blue surgery boot covered the right heel dressing.

On 8/14/13 at 4:dpm, administrative nursing staff B entered the resident's room to perform wound care treatment to the resident's wounds. Staff washed hands prior to beginning treatment. Staff report that the supplies for this resident say in this room since there is an active infection. The container was then brought over and sat directly on the electric wheelchair seat. Resident right

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great toe wound noted to be red in color, with wound bed white and noted a small amount of slough. Staff cleansed the wound and changed gloves but failed to wash their hands. Mepilex AG was applied to the wound bed and secured with medipore tape. Staff washed hands and applied gloves for cleansing of the heel wound. The heel was cleansed and staff changed gloves but failed to wash their hands. A hydroferra dressing was applied and secured with Tegaderm. Staff washed hands and applied gloves for cleansing of the left stump wound. Staff cleansed the wound and changed gloves but failed to wash their hands. Hydrometra dressing was applied and secured with Tegaderm. Staff failed to wash their hands after completion of the dressing change and gloves removed. Staff then touched the rest of the hydroferra blue dressing with bare hands to put it back in the package for the next dressing change and after this contamination the staff washed their hands. This staff failed to wash their hands with glove changes during the treatment procedures to the resident's 3 wounds.

On 8/14/13 at 3:25 pm, direct care staff M reported, "The resident was recently a 2 person transfer but I haven't had to do much with [the resident] today. If I notice redness or breakdown, scratches, hives or a rash I would tell the nurse. I make sure there is a wedge under [the resident] when in bed and [he/she] wears a boot to to keep pressure off the heel also."

On 8/15/13 at 2:43 pm, direct care staff L reported, "We put a foot brace on and fold a pillow so that there is no pressure to the residents heel and a pillow under the stump to keep it up in the air. During the day [the resident] will not let

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us do much with [him/her]."

The facility policy and procedure for dressing and treatments, with no date, revealed, "...prepare clean field, create a barrier, gather needed supplies, place supplies on clean field, prepare bag for soiled items, wash hands and apply gloves...cleanse wound per M.D. orders, dispose of cleaning supplies in bag, remove gloves and wash hands, apply clean gloves, apply dressing per physician order, dispose of unused items into bag, remove gloves and wash hands, ensure resident's comfort and call light are within reach, soiled supplies disposed of in a biohazard container..."

The facility failed to provide appropriate wound care treatment technique to prevent new infections or the spread of the current wound infection.

- The electronic medical record revealed resident #13 admitted on 1/14/13, with a readmission on 3/9/13. Diagnoses included, pressure ulcer stage 4, pressure ulcer unstageable right ischium (lower buttock area), diabetes type II (when the body can't use glucose, there's not enough insulin made or the body can't respond to the insulin) and neuropathy idiopathic (when nerve damage interferes with the peripheral nervous system's ability to function. When no cause can be determined, it is called idiopathic neuropathy).

The quarterly MDS (minimum data set), dated 7/17/13, revealed, resident with severely impaired cognition, with a BIMS (brief interview for mental status) score of 2. It identified the resident required extensive assist of one staff with dressing, and personal hygiene, extensive assist

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of two with bed mobility, total dependence and one staff for toilet use and locomotion, and total dependence on two staff for transfers. It identified the resident with an indwelling foley catheter and a colostomy.

The CAA (care area assessment), for pressure ulcers, dated 1/25/13, revealed, "Pressure ulcer to right ischium is unstageable due to brown necrotic tissue to wound bed. Moderate amount of yellow/brown drainage noted. Peri wound tissue is pink, macerated. Measurements 7 cm x 6.4 cm x 2 cm deep. Pressure ulcer to coccyx is stage 3. Minimal amount of serosanguinous drainage noted. Peri-wound tissue is pale, dry. Measurements 1.7 cm x 4 cm x 2.2 cm.

The care plan dated 5/8/13, instructed staff, "Ensure low air loss mattress to bed. Encourage resident to float heels when in bed and encourage use of heel protectors when in bed. Encourage and assist resident to turn and reposition every 1-2 hours. Assist resident with incontinent care as needed and apply moisture barrier after incontinent episodes. Measure and assess wound and skin check every week. Notify MD [medical doctor] of noted signs and symptoms of impaired skin integrity. Notify MD as needed for lack of response to treatment, if no improvement noted within 2-4 weeks. Diabetic supplement daily for wound healing and weight loss per dietician recommendation and liquid protein per order."

A progress note, dated 8/8/13, revealed, "Resident to doctor for wound care in [another town] via company van transported by two facility staff. Received new orders. Wound vac to be applied to right ischial and coccyx wound at 125

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mm/hg [millimeters of mercury] to be changed twice weekly. In meantime daily wash wound with liquid milk soap and water or wound cleanser and pat dry. Use Alcare wipes and calazime to periwound area as needed. Daily gentamicin sulfate ointment 0.1% to wound bed, then drawtex to wound bed making contact with all wound bed and stacked to wound opening then cover and tape. Change wound dressing daily and if soiled in between. 100% off loading to wound. Prostat 1 oz [ounce] TID [three times daily]. Recommends keeping FBS [fasting blood sugar] < [less than] 120."

A weekly skin action tool, dated 8/8/13, revealed, "Skin warm, dry and intact. Colostomy intact. [Coccyx] measuring 4 cm[centimeters] by 4.3 cm by 3.5 cm. [Ischial] measuring 3 cm by 2 cm by 5 cm. Foul odor with greenish/bloody drainage with blood clots. Skin red around wounds. Dark reddish color noted near ischial wound with some breakdown noted. No other skin issues noted at this time."

A wound care clinic note, dated 7/15/13, revealed, "Outpatient visit evaluate and treat chronic stage 4 coccyx and right ischium. No odor, less drainage from both wounds, peri wound tissue dry but no areas of excoriation. Both wounds are contracting, no slough, beefy wound walls and coccyx base beefy, depth of both wounds have not decreased. Felt rough bone at base of right ischial wound. Wound measurements: Ischial 1.8 cm x 2.3 cm x 4.7 cm. Coccyx 3.8 cm by 2.5 cm by 3.6 cm....Bone scan for possible osteomyelitis (an infection in a bone) right ischium. Current treatment will be continued at this time since drainage control and wound contracting is present..."

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On 8/13/13 at 3:53 PM, observation revealed, resident on the left side in bed, with a special mattress.

On 8/14/13 at 10:00 PM, licensed nursing staff T, entered the resident's room with a basin filled with dressing changing supplies to provide treatment to the resident's pressure ulcers. Staff then removed their gloves and washed hands. Gentamicin ointment was placed in 2 plastic medication cups and calazime was placed in a 3rd cup. The nurse precut the Isolate foam for the wounds and placed it on the over bed table. Staff T then placed tape on the larger piece of foam dressing and labeled it with nurses initials and date. Staff then washed their hands and donned new gloves. Both administrative nursing staff B and another unidentified direct care staff wore gloves and assisted to hold the resident onto the right side. Blankets were moved with all staff's gloved hands. Staff T then removed the soiled dressing from the resident's buttocks, and removed the foam type dressings from the 2 wound beds. Coccyx wound was sprayed with wound cleanser and 4 x 4' s' were used to clean out the wound. Staff changed their gloves but failed to wash their hands before continuing and applied gentamicin to the coccyx wound with gloved finger, placed 3 pieces of drawtex into the wound, Alcare wipes used to the skin surrounding the coccyx wound. Outer foam dressing then applied to coccyx wound. Staff removed their gloves without washing their hands and then picked up the outer foam for the ischial (lower buttock) wound with bare hands. A piece of tape was applied to the foam dressing and then staff handed the dressing to administrative nursing staff B. Staff B previously held the resident on

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F 314	Continued From page 49 the side during the first coccyx dressing change and directly touched the face of the new ischial dressing without changing gloves or washing hands. Staff T then applied a second piece of tape to the foam and labeled/dated the dressing. Wound cleanser was applied to ischial wound and 4 x 4 used to clean wound. Gentamicin was then applied to ischial wound with the gloved finger of staff T, followed by the drawtex and then the outer contaminated dressing. Staff T verified the ischial wound approximately 1.5 inches in depth. Resident was repositioned with a wedge placed under the right side. Licensed nursing staff T and B directly touched the dressings for the resident's 2 pressure ulcer wounds with contaminated hands and potential for the spread of infection. The facility policy and procedure for dressing and treatments, with no date, revealed, "...prepare clean field, create a barrier, gather needed supplies, place supplies on clean field, prepare bag for soiled items, wash hands and apply gloves...cleanse wound per M.D. orders, dispose of cleaning supplies in bag, remove gloves and wash hands, apply clean gloves, apply dressing per physician order, dispose of unused items into bag, remove gloves and wash hands, ensure resident's comfort and call light are within reach, soiled supplies disposed of in a biohazard container..." The facility failed to provide appropriate wound care treatment technique to prevent new infections or the spread of the current wound infection, for this resident with stage 4 pressure ulcers.	F 314		
F 323	483.25(h) FREE OF ACCIDENT	F 323		9/20/13

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F 323 SS=D	Continued From page 50 HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility had a census of 31 resident. The sample of 14 residents included 3 reviewed for accidents. Based on observation, interview, and record review, the facility failed to ensure 3 of 3 sampled residents (#6, #23, & #24) reviewed for accidents received adequate supervision and assistive devices to prevent repeated accidents. Findings included: - The electronic face sheet, revealed resident #6, readmitted to the facility on 12/3/08, with the following diagnosis; multiple sclerosis (progressive disease of the nerve fibers of the brain and spinal cord), glaucoma (an abnormal condition of elevated pressure within an eye caused by obstruction to the outflow), osteoporosis (disorder characterized by abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk), anxiety disorder (a mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, melancholy, dejection,	F 323		

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worthlessness, emptiness and hopelessness), and muscle spasm.

The annual MDS (minimum data set) 3.0 dated 7/5/13, revealed the resident had a BIMS (brief interview for mental status) score of 15, indicating cognition intact. For ADL's (activities of daily living) the resident required limited staff assistance for bed mobility, transfers; and extensive staff assistance for toilet use. Balance is not steady, and had limitation in range of motion to upper and lower extremity on both sides. Mobility per wheelchair. Occasionally incontinent of urine and always continent of bowel. No falls documented. The resident received restorative nursing services for transfers 3 days for 15 minutes.

The CAAS (care area assessment summary), dated 7/12/13, revealed for ADL's the following; "Requires assistance with ADL's related to diagnosis of MS (multiple sclerosis). Is at risk for decline in independence with ADL's. Is non ambulatory. Wheels self in wheelchair, limited assist at times for maneuvering through doorways. Has impaired balance during transfers. Has impaired ROM (range of motion) to right lower extremity related to MS..."

The CAAS, dated 7/12/13, for falls, documented the following; "At risk for falls related to impaired balance during transfers, not able to maintain standing balance for longer than a few seconds, impaired ROM to right lower extremities related to MS..."

The Fall Assessment, dated 7/4/13 had a score of 10, with a score of 10 or more represents HIGH RISK for falls and must be care planned.

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F 323	Continued From page 52 The care plan reviewed last on 5/31/13, documented the following; "--Remind the resident to lock wheelchair prior to transfer. --Restorative nursing program: maintain and improve transfers. Staff assist with transfers and use parallel bars to increase strength and ability to transfers every shift. --Assist with position changes for comfort as needed. Has increased anxiety when clothing or bedding feels restrictive or 'bunches up'. --Encourage the resident to call for assist with transfers when having periods of weakness due to MS. --Keep bed in lowest position with brakes locked. Mobile via wheelchair propelled by self. May occasionally require staff to propel. --Provide toileting assistance as the resident allows, requires reminders to ask for assist with toileting, but allow the resident to toilet self to maintain as much independence as possible. --Remind me to wear shoes or gripper socks when transferring to assure safe transfers. Re-educate me in regards to transferring self. Explain the need to use call light to prevent injury and allow staff to be present when transferring. I like to go barefoot and will refuse to wear footwear at times. --Has transfer pole in room to assist with transfers, Educate the resident on use of pole as needed." Observation, on 8/14/13 at 7:00 AM, revealed the resident resting quietly in bed with eyes closed, bed in the lowest position, and personal alarm in place.	F 323		

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On 8/14/13 at 8:32 AM, the resident sitting on the side of the bed. Direct care staff R encouraged the resident to used the transfer pole. The resident grabbed the transfer pole and staff R assisted the resident to transfer to the manual wheelchair. Staff R then gave the resident (his/her) call light, due to the resident wanting to eat breakfast and have (his/her) bed made, with PA (personal alarm) in place. However, the resident lacked wearing non-skid socks or shoes as planned.

On 8/14/13 at 8:52 AM, the resident transferred, to the toilet with direct care staff U providing standby assistance. The resident grabbed the transfer bar in the bathroom, stood, pivoted and sat on the toilet. After the resident finished toileting, transferred self to manual wheelchair, with direct care staff U providing standby assistance. Personal alarm placed on the resident. However, the resident continued failure to wear the non-skid socks, and instead wore regular white socks.

On 8/14/13 at 9:06 AM, direct care staff Q, assisted the resident to stand, from the manual wheelchair, with gait belt, using the Parallel bars, without non-skid socks.

On 8/14/13 at 1:18 PM, direct care staff R took the resident to room per manual wheelchair. Came back out of the room and went to supply room and obtained a package of yellow non-skid socks, and placed the resident's name on them, and then placed a pair of yellow non-skid socks on the resident.

Interview, on 8/14/13 at 8:35 AM, direct care staff R reported, "The resident has MS, a progressive

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illness. Up until the last couple of weeks [he/she] had been independent. The resident has a body alarm, one person assist for transfers. I would like to suggest we have a report. Sometimes we do. The nurses are very good about telling us. The body alarm, provides better attention to what [his/her] needs are. The resident will use [his/her] call light. The bed is to be in the lowest position."

On 8/14/13 at 9:02, direct care staff R reported, "The body alarm is usually documented on the ADL flow sheet." Review of the ADL flow sheet, dated 8/2013 lacked documentation of the resident to have a body alarm.

On 8/14/13 at 1:15 PM, direct care staff R reported, "The resident is a fall risk, [he/she] should probably have non-skid socks on. I will take the resident to his/her room and put non-skid socks on."

On 8/14/13 at 2:20 PM, direct care staff R reported," The resident now has on non-skid socks. I went and got a package of them and put the resident's name on them, so [he/she] would have them."

On 8/14/13 at 4:45 PM, direct care staff O reported, "The resident used to be very independent, does have a tendency to take off, especially if we are busy. Direct care staff O not aware of the resident having a fall in the last 30 days. The staff are to look at the care plans, and to follow the care plans."

On 8/14/13 at 1:45 PM, administrative nursing staff C reported, "When a resident falls, we do an Unusual Occurrence Form, and document on it for 3 days. We do not usually document in the

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nurses notes about a resident who had a fall. The nurse can update the care plan for a fall if they can decide on an intervention. I just updated the resident's care plan from the Unusual Occurrence Form. Did not realize how soon an intervention needed to be implemented [following a resident's fall]."

On 8/15/13 at 9:20 AM, administrative nursing staff B reported, "The CNA's [certified nurses aide] are told the interventions by the nurse and the nurse is to monitor the CNA's to make sure the interventions are being done. The resident did have at one time non-skid socks and then they probably disappeared and new ones not obtained."

The facility undated policy and procedures, for Unusual Occurrence Record, documented the following: "Policy: To provide a monitoring and tracing system that assists the facility in preventing unusual occurrences. Definition: An unusual occurrence or accident/incident is an unexpected, unintended event that can cause a resident bodily injury."

The facility failed to provide adequate supervision and assistive devices of the planned non-skin socks, to prevent repeated accidents for this resident who experienced 3 falls from 7/30/13 to 8/7/13.

- The resident's electronic face sheet revealed, resident #23, readmitted to the facility on 7/18/13, with the following diagnosis; debility (feebleness, weakness, or loss of strength), pain, scoliosis (lateral curvature of the spine) associated with other condition, osteoporosis (disorder

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characterized by abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk), and osteoarthrosis (condition of chronic arthritis without inflammation).

The 14 day MDS (minimum data set), dated 7/3/13, revealed the resident had a BIMS (brief interview for mental status) score of 13, indicating intact cognition. The resident required for ADL's (activities of daily living) extensive staff assistance of 1 for transfers, walks in room/corridor, locomotion on/off unit. The resident's balance not steady, and functional limitation in range of motion to upper extremity on 1 side. Mobility per wheelchair/walker. The MDS documented the resident with fall since admission/entry or reentry or the prior assessment, with 1 major injury.

The Fall Assessment, dated 6/19/13 recorded a score of 14, "[A score of 10 or more represents HIGH RISK and needs to be care planned]."

The care plan reviewed last on 8/15/13, documented the following:
"--Keep bed in lowest position with brakes locked.
--Keep call light in reach at all times.
--Keep personal items and frequently used items within reach.
--Leave night light on in room above bed.
--Rule out infection as cause of changes in cognition, gait, balance.
--11/12/12-Fall intervention: Remind resident to not sit on edge of recliner.
--3/11/13-PT [Physical Therapy] for weakness--5/4/13-Therapy goals met.
--3/22/13-Medication review by physician and consult pharmacist.
--6/27/13-Fall: medication review.

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--7/16/13-Fall-Utilize personal alarm while in residents room for increased alert of staff."
--Encourage the resident to call for assistance with ADL's.
--Encourage to stand upright while walking.
--Instruct the resident in proper use of rolling walker.
--Keep area free of clutter/obstacles
--Monitor/record/report presence of pain/intolerance during ambulation.
--Observe for good endurance and steady gait.
--Observe for safe ambulation and proper use of rolling walker.
--Provide adequate rest periods between activities.
--Provide extensive assistance for ambulation."

The electronic progress notes, dated 7/16/13 at 2:00 PM, documented the following, "CNA [certified nurses aide] called this RN [registered nurse] to resident's room. Resident was noted to be on the floor on [his/her] back. Complaining of left hip pain upon active and passive ROM [range of motion]. Doctor notified. Received order to send to hospital ER [emergency room] for evaluation, ... EMS [emergency medical services], notified."

The progress note lacked any information regarding if the fall had been witnessed or not.

The electronic progress notes, dated 7/18/13, documented, "Resident readmitted from hospital, diagnoses of pelvic fracture, arrived via company van, at noon with Activities/Social services staff D."

Observation, on 8/12/13 at 11:50 AM, revealed

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the resident with a personal alarm in place, and the call light in reach.

On 8/12/13 at 4:30 PM, the resident in recliner in room with personal alarm in place and call light in reach.

On 8/19/13 at 7:45 AM, the resident sitting at the table in [his/her] room, feeding self breakfast. Reports breakfast is good. The resident's personal alarm not in place attached to the resident.

On 8/19/13 at 11:30 AM, the resident ambulated with a roller walker in the hall with consultant staff V. The resident's gait steady. Consultant staff V reported, "The resident did not have a personal alarm on when I stood the resident up from the recliner."

Interview, on 8/14/13 at 8:42 AM, direct care staff R reported, "We leave the door open. Before the last fall, the resident was pretty independent, would need to remind the resident to use [his/her] call light. The resident fractured [his/her] pelvis. The resident has a body alarm and we are to leave the door open."

On 8/14/13 at 4:42 PM direct care staff O reported, "We take the resident to the bathroom, and dress [him/her]. Since the resident fell and cracked [his/her] pelvis, we started having to do everything for [him/her] except feed [him/her]. As soon as the resident fell they put the monitor on."

On 8/14/13 at 2:15 PM, administrative nursing staff C reported, "The resident had a fall and went to the hospital. We did not do an Unusual Occurrence Form when this happens because

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the resident isn't in the facility anymore to monitor. We put an intervention in the care plan."

On 8/19/13 at 7:45 AM, direct care staff Q reported, "The resident does not have a personal alarm any more."

On 8/19/13 at 7:46 AM, administrative nursing staff B reported, "The resident's personal alarm taken off. The resident said [he/she] would use the call light and not get up on [his/her] own."

On 8/19/13 at 7:47 AM, the resident sitting at the table in the room, eating breakfast. The resident reported, "I told the girls I would use my call light."

The facility failed to provide adequate supervision and assistive devices to prevent repeated accidents, for this resident with a history of falls and fractured pelvis.

- The electronic face sheet, revealed resident #24, admitted to the facility on 1/5/10, with the following diagnoses: dementia (progressive mental disorder characterized by failing memory, confusion), delusional disorder (an untrue persistent belief or perception held by a person although evidence shows it is untrue), anxiety state (a mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), Alzheimer's (progressive mental deterioration characterized by confusion and memory failure), depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, melancholy, dejection, worthlessness, emptiness and hopelessness), insomnia (inability to sleep) symptom.

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The quarterly MDS (minimum data set) assessment, dated 7/30/13, revealed the resident with a BIMS (brief interview for mental status) score of 3, indicating severely impaired cognition. The resident with delusions, and other behavioral symptoms not directed toward others. For ADL's (activities of daily living) the resident required, supervision of 1 staff for bed mobility; limited staff 1 staff assistance for transfers, walk in room, and toileting; and extensive stave assistance of 1 for locomotion. The resident's balance as not steady, no impairment in functional range of motion, and mobility per wheelchair. The MDS documented the resident had since prior assessment, two or more, non-injury falls. The resident received restorative nursing, 7 days for walking.

The Fall Risk Assessment, dated 4/27/13, revealed a score of 10, a score of 10 or more indicating the resident at high risk for falls.

The care plan, dated 6/6/13, documented, "Check on the resident every 2 hours. Sits self on the floor and has poor safety awareness. Monitor for delusional thinking. Ensure that eyeglasses are clean and in place daily. Rule out hypertension as a reason for gait changes as indicated. Monitor my vital signs weekly and prn [as needed]. I see [consultant staff W] as needed. Please notify my PCP [primary care physician] of [consultant staff W] recommendations. Monitor for changes in gait and balance. Will ambulate with staff assist using front wheeled walker. Will ambulate without staff assistance at times."

The Unusual Occurrence Record, dated 7/25/13, documented the following: "For 6 AM-6 PM, Injury Sustained: Bruising, Location: right side of forehead. The resident is alert and full range of

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motion with no impairment. Comments/notes: Resident is alert, pain to bruise if touched. Denies headache at this time." Further documented, "On 7/25/13 for 6 PM-6 AM, Bruise noted to the right side of the forehead, measuring approximately 2 cm [centimeter] by 0.5 cm, no other injuries noted."

The Kansas Department of Aging and Disabilities investigation form, dated 7/25/13, documented, "On July 7/25/13, at approximately 6:30 AM, the staff walking by the resident's room, noticed that [the resident] was lying on the floor and not [his/her] recliner where they last saw [the resident]. CNA [certified nurses aide] alerted co-workers. The nurse assessed the resident at that time and noted hematoma above the resident's right eye, no other injuries noted...Personal alarm put in place on 7/25/13."

On 8/13/13 at 4:44 PM, observation revealed the resident rested on the bed with a personal alarm attached. However, the control box lay on the pillow beside the resident and well within the resident's reach.

On 8/13/13 at 4:36 PM, observation revealed, the resident assisted with ambulating in the hallway with unsteady gait by 2 staff and a gait belt on.

On 8/14/13 at 7:17 AM, observation revealed the resident rested on the bed with the personal alarm attached to the resident. However, the control box lay on the bed next to the resident and unattached to anything else. At that time, direct care staff R assisted the resident into a wheelchair. Direct care staff R then placed a gait belt on th resident and ambulated the resident to the dining room with another CNA following

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behind with the wheelchair.

On 8/14/13 at 8:02 AM, observation revealed the resident in the recliner in ([his/her) room. The personal alarm attached to resident and the control box placed in recliner seat behind resident's back, but within the resident's reach.

On 8/14/13 at 8:36 AM, observation revealed the resident resting on the bed. The personal alarm on the resident, but the control box rested on the bed not attached to anything.

On 8/14/13 at 9:35 AM, the resident yelled out "help" attempting to sit up on the side of the bed. The alarm attached to the resident but the control box rested on the bed unattached to anything. At 9:38 AM, an unidentified direct care staff assisted the resident to the bathroom.

On 8/14/13 at 2:40 PM, observation revealed, the resident stood in the room doorway yelling for help. The resident held the alarm control box in [his/her] hand with the clip attached to the resident and not sounding. Consultant staff S walked by the resident's room, while pushing another resident in a wheelchair, stopped and looked at the resident while the resident yelled for help and then proceeded with the other resident in the wheelchair to the therapy room. After 4 minutes of the resident yelling for help, another unidentified direct care staff responded to the resident and assisted the resident with needs.

On 8/13/13 at 4:44 PM, direct care staff R reported, "The resident has had the alarm since [his/her] last fall. We can look to see what to do for [him/her] on our CNA care plans on the ADL book."

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On 8/14/13 at 4:14 PM, direct care staff K reported, "Last week [the resident] walked in the hall with [his/her] shirt pulled up around [his/her] ears. The alarm was attached to [his/her] shirt and she carried it so it didn't sound. This is more of an afternoon thing for [the resident] [getting up out of bed]."

On 8/14/13 at 4:30 PM, direct care staff O reported, "I was not here when the resident fell. I don't like the alarm, you can't hear it, and they will come undone if the resident barely moves. The personal alarm doesn't work for [the resident]. The resident needs a pressure mat."

On 8/15/13 at 10:20 AM, administrative nursing staff B reported, "To determine if the personal alarm was effective for this resident, would be determined by whether or not [the resident] had any further falls." Administrative nursing staff B reported not aware that the resident ambulated in the hallway with the alarm and acknowledged that the incidents were probably not documented. Furthermore, they [facility staff] would probably change the intervention. "The care plans are updated the day of the incident or right after. Care plans are usually unavailable to nurses prior to [administrative nursing staff C]. Evenings will call to see about interventions."

The facility undated policy and procedures for Unusual Occurrence Record documented the following: "Policy: To provide a monitoring and tracing system that assists the facility in preventing unusual occurrences. Definition: An unusual occurrence or accident/incident is an unexpected, unintended event that can cause a resident bodily injury."

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F 323	Continued From page 64 The facility failed to provide adequate supervision and appropriate assistive devices to prevent repeated accidents for this resident with history of falls, related to the continued use of the inadequate intervention of the personal alarm, which the resident removed or carried with them alone.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced	F 329		9/20/13

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by:
The facility reported a census of 31 residents. The 14 selected residents included 5 reviewed for unnecessary medications. Based on record review, observation, and interview, the facility failed to monitor for the adverse consequences associated with black box warning for medications administered to 2 of the 5 selected residents (#5 and #19)

Findings included:

- The electronic medical record for resident #5 revealed the resident admitted to the facility on 7/29/09, with the latest return on 10/18/11, and diagnosis which included atrial fibrillation (rapid, irregular heart beat).

The physician ordered the following medications with (BBW) black box warnings: Coumadin 5 mg (milligrams) by mouth daily, on 4/9/13.

According to federal drug administration website, Coumadin had a black box warning of: "Bleeding risk. Coumadin can cause major or fatal bleeding. Perform regular monitoring of labs in all treated patients. Drugs, dietary changes, and other factors affect INR (International Normalized Ratio) levels achieved with Coumadin therapy."

Review of the plan of care, revealed the facility failure to include the BBW specific to the adverse consequences for the Coumadin.

Review of the nurses note, dated 6/26/13 at 1:46 pm, revealed "...Continue Coumadin at 5 mg daily and recheck INR in 2 weeks."

Nurses note, dated 7/17/13 at 5:19 pm,

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documented, "Continue Coumadin at 5 mg. Recheck in 2 weeks per doctor office."

After review of the laboratory results, there was no lab obtained on or around July 9, 2013, when the lab was ordered to have been rechecked. It was, however, drawn later on 7/17/13. The order received was to recheck the lab in 2 weeks and as of 8/19/13 it had not yet been drawn until it was brought to the administrative nursing staff attention.

Observation on 8/14/13 at 7:30am, revealed the resident sitting in electric wheelchair at the dining room table, and with a light purple bruise fading to the right forearm.

Interview on 8/15/13 at 10:00 am, administrative nursing staff B reported, "We got our BBW out of the Lexicomp book."

On 8/19/13 at 2:40 pm, administrative nursing staff B reported, "The last PT/INR (Prothrombin time) was obtained on 7/17/13. Yes, it was done after it should have been. We will be getting it done this week."

On 8/19/13 at 3:00 pm, administrative nursing staff B reported, "When a lab is missed, the physician is notified. We will get a new order for the lab."

The policy and procedure for medication-boxed warnings, with no date, revealed, "...It is the policy of [the facility] that all medications including boxed warnings will have the appropriate literature available to healthcare staff located with the residents MAR [Medication Administration Record] and also in the residents plan of care...All

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resident medications referenced in Lexicomp's Geriatric Dosage Handbook 2012, 17 th Edition..."

The policy and procedure for laboratory test request, with no date, revealed, "...The Director of Nursing/designee will be responsible for ensuring that (1) all requested laboratory tests are obtained and the results are reported to the physician in a timely manner..."

The facility failed to monitor for the adverse consequences associated with the black box warning for the administration of Coumadin to this resident and failed to appropriately obtain laboratory tests to ensure appropriate levels were achieved, and the medication not unnecessary.

- The electronic medical record for resident #19 revealed the resident admitted to the facility on 2/13/11 with the latest return of 5/23/12, and diagnoses of migraine and chronic (persisting for a long period, often for the remainder of a person's lifetime) pain.

Physician's orders dated 7/1/12, revealed the following medication with (BBW) black box warnings: Duragesic/Fentanyl 25 micrograms per hour one transdermal every 3 days for chronic pain.

According to federal drug administration website, fentanyl transdermal patch/Duragesic patch has a black box warning of: "Abuse potential, respiratory depression and death."

Review of the plan of care, revealed that the plan failed to include the BBW specific to the adverse consequences for the Fentanyl/Duragesic patch.

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F 329	Continued From page 68 Observation on 8/13/13 at 4:53 pm, revealed the resident wheeling self in wheelchair, heading to the dining room for supper without any signs of pain noted. On 8/15/13 at 10:00 am, administrative nursing staff B reported, "We got our BBW out of the Lexicomp book." The policy and procedure for medication-boxed warnings, with no date, revealed, "...It is the policy of [the facility] that all medications including boxed warnings will have the appropriate literature available to healthcare staff located with the residents MAR [Medication Administration Record] and also in the residents plan of care...All resident medications referenced in Lexicomp's Geriatric Dosage Handbook 2012, 17 th Edition..." The facility failed to monitor for the adverse consequences associated with the black box warning for the administration of Fentanyl/Duragesic patch to this resident.	F 329		
F 353 SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing	F 353		9/20/13

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care to all residents in accordance with resident care plans:

Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.

Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.

This REQUIREMENT is not met as evidenced by:
The facility identified a census of 31 residents. Based on record review, interviews, and observations, the facility failed to provide sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental and psychosocial well-being for the residents of the facility.

Findings included:

- On 8/12/13 resident interviews revealed the following statements when asked, "Do you feel there is enough staff available to make sure you get the care and assistance you need without having to wait a long time? " :

1. "No. We are shorthanded. If I turn on the light to go to the bathroom, by the time they get here, I have already wet myself. I have had to wait up to 40 minutes sometimes for them to answer my light."

2. "No. All shifts and double bad on weekends."

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3. "No. During meals everyone is in the dining room and nobody is on the floor to take care of residents who stay in their room."

4. "No. They seem short on staff and don't always get here fast enough to help go to the bathroom."

5. "No. Continually short staffed. When asked, the answer they tell me is they need more staffing ...most of time since I have gotten here is shortage of staffing."

6. "No ...when the census goes down, the staffing goes down. Just because the census goes down, doesn't mean the workload isn ' t here."

7. "No. All shifts and all days."

8. "No. Not always. Sometimes have to wait 30 minutes to an hour. They are short staffed here. Happens maybe 2 times in a month."

Observation, on 8/13/13 at 4:36 PM, revealed a call light on the East resident hallway turned on and was answered, 8 minutes later, by staff at 4:44 PM.

On 8/14/13 at 8:30 AM, direct care staff U stated, "We do work short and it's a lot. Throughout the week we have an aide on west hall, restorative aide works east hall and will get everybody up. I try to answer lights. I work east hall after I pass the morning meds until I have to pass meds again. I also give 1-2 showers a day. On a 6 hour day, I will have 1 shower or none. I usually have a 12 hour shift to get the showers done. The nurses, if we are lucky enough, will answer call

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lights and they are watching the floor. We have to bust bottom and get it done if the nurses aren't answering the lights. The lights are green when it first turns on and I think it turns yellow in 60 seconds. If it goes red, then it goes to the nurses. We get told that corporate won't allow more hours to have enough help. They tell us the census is down. "

On 8/14/13 at 12:23 PM, interview of direct care staff K stated, "We have had to work short before if someone calls in. On Monday [8/12/13], we had a call in, but they had the transportation aide work the floor."

On 8/14/13 at 2:20 PM, direct care staff M stated, "Once a month or so we work short. Usually somebody calls in and nobody wants to come in."

Observation, on 8/15/13 at 8:18 AM, revealed a resident room on the east resident hallway with call light answered, 19 minutes later, by staff at 8:37 AM, after the CNA's (Certified Nursing Assistant) were re-paged six times.

On 8/15/13 at 8:20 AM, a family member visiting a resident stated the resident, "Had [his/her] call light on for a while and needs to go to the bathroom now. This happens all the time, at least several times a month. If I had to put a number on it I would say at least 1 time a week, but I bet more often. I'm in here every day to see [the resident], and I have seen [him/her] wet or soiled because they don't have enough staff to take care of these people. They are always shorthanded and have an excuse for why they can't take good care of these people. I have told them before that I have no problem pulling [the resident] out of here if they can't give [him/her]

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the care [he/she] deserves." At 8:50 AM, the resident family member reported being very upset with the facility because, "[The resident] soiled themselves before the staff made it in to help and [the resident] is now crying and ashamed."

Observation, on 8/15/13 at 8:20 AM, revealed a resident sitting in wheelchair in the east hallway, with sweater pulled up over the back of the resident's head, yelling, "Help me." At 8:32 AM, 12 minutes later, administrative nursing staff B approached the resident asking what [the resident] needed. The resident reported the need to go to the bathroom and to now have [his/her] clothes changed.

On 8/15/13 at 9:00 AM, a resident room on the east resident hallway with call light on for 18 minutes, before being answered by a staff member.

On 8/15/13 at 10:20 AM, interview of administrative nursing staff B reported, "I have an aide, med aide and restorative aide during the days. The med aide goes to the floor after meds are passed and the restorative aide goes to do restorative. When I'm the nurse, I try to have another aide. It's all because of college starting. I see what you're saying. I don't have an answer for you [when asked what would happen if a resident fell on the opposite end of the building when there is only one aide for both ends of the building]. Yes, this building is a full city block long and it is a long way from one end to the other. I do see the problem ...there are just not enough of them [CNA's] ...I don't think they [corporate] realize how busy the facility is ...but there comes a time when you have to look at patient care ...PRN [as needed] staff will not come in. It gets

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to where [the staff] are tired. Everyday has an RN [registered nurse] scheduled and when we have a weekend where it is an LPN [licensed practical nurse] back to back on the schedule, I just come in and get my work done. I realize we have staffing issues."

On 8/16/13 at 10:45 AM, direct care staff R stated, " Will you tell them we need more help..."

Observation, on 8/19/13, revealed a bathroom call light in the west resident hallway on at 9:06 AM, with staff re-paged 7 times prior to being answered by staff, 22 minutes later, at 9:28 AM.

On 8/19/13, a resident bedroom call light in the east hallway came on at 9:15 AM, with staff re-paged 3 times, prior to being answered at 9:24 AM, 9 minutes later.

Observation, on 8/19/13, revealed a resident's bedroom call light on the west hallway on at 9:17 AM, was re-paged 2 times, prior to being answered at 9:24 AM, 9 minutes later.

Observation, on 8/19/13 at 2:00 PM, revealed a resident standing up from the east lobby area couch, and very unsteady on feet. The resident agreed to sit back down so facility staff assistance could be found. Dietary staff F found walking down the hallway and informed of the resident's condition. Dietary staff F reported that the administrative staff C, currently acting as charge nurse, could be found in the office of administrative staff B. Administrative staff C found, informed of situation, and then staff C went to take care of (the resident) needs.

On 8/19/13 at 8:45 AM, direct care staff R stated,

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F 353	Continued From page 74 " ...We just flat out don't have enough help to take care of these residents. The other day there were just 2 of us and the other one took [a resident] into the shower which left me on the floor by myself. I had to go to the opposite end to answer a call light and another [resident] was on the other side yelling out that [he/she] needed help and the surveyor had to bring it to my attention since I had to go to the other side. [The residents] deserve better care than what the company is allowing us to give." On 8/19/13 at 10:23 AM, a resident reported, "We have a lot of help when the surveyors are here. If you weren't here, we wouldn't have near as much help as we have. I had my light on Friday night for over 10 minutes and was having a very hard time getting my breath. They gave me my inhaler and a breathing treatment, but 10 minutes is too long and I could have been in big trouble waiting that long when I was having difficulty breathing. There just aren't enough people to take care of us." The facility failed to ensure sufficient qualified nursing staff available on a daily basis to meet residents' needs for nursing care, in a manner and in an environment which promotes each resident's physical, mental and psychosocial well-being, thus enhancing their quality of life.	F 353		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food	F 371		9/20/13

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F 371	Continued From page 75 under sanitary conditions	F 371		

This REQUIREMENT is not met as evidenced by:
The facility reported a census of 31 residents. Based on observation and staff interview, the facility failed to store and prepare food under sanitary conditions in 1 of 1 kitchens, for all residents.

Findings included:

- The kitchen initial tour on 8/12/13 at 8:39 am revealed:

a) The refrigerator held approximately 60 chocolate health shakes which revealed no open or expiration dates on the cartons and lacked any date written on the box.

The kitchen environmental tour on 8/14/13 at 2:20 pm revealed:

a) Seven plate warmer holders contained melted plastic areas with insulation exposed and not able to be sanitized.

b) Two packages of hamburger buns, 3 packages of hot dog buns, 2 loaves of wheat bread and 4 loaves of white bread, all contained a (expired) date of "best by 8/12/13."

c) The ice machine drain at the back of the machine contained a black hose with a "T" in it with PVC piping approximately 3 inches in length

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F 371	Continued From page 76 and 1/2 inch in diameter. The end of the PVC pipe rested directly on the drain, revealing an inadequate air gap in the drainage line. d) The stove back splash, behind the burners, held a large amount of black colored substance measuring an area approximately 2 feet x 2 feet. e) Cob webs noted to the inside of hood and with rust colored substance to the hood, across most of the back and on the sides. f) The back of the hand washing sink held a brown substance that measured approximately 6 inches in length. Observation on 8/15/13 at 4:45 pm, the inadequate air gap to the ice machine remained unchanged. On 8/15/13 at 5:00 pm, maintenance staff G verified the inadequate air gap on the ice machine. Interview on 8/12/13 at 8:41 am, dietary staff F reported, "The plate warmer holders can be easily thrown out because we have new ones on the shelf. The tabs where the dates were written for the shakes must have been cut off when they put the box in the refrigerator." The facility failed to store and prepare food under sanitary conditions in 1 of 1 kitchens, for all residents.	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be	F 428		9/20/13

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reviewed at least once a month by a licensed pharmacist.

The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.

This REQUIREMENT is not met as evidenced by:
The facility reported a census of 31 residents. The 14 selected residents included 5 reviewed for unnecessary medications. Based on record review, observation, and interview, the facility consulting staff failed to identify the facility's lack of adequately monitoring of the adverse consequences associated with black box warning for medications administered to 2 of the 5 selected residents (#5 and #19).

Findings included:

- The electronic medical record for resident #5 revealed the resident admitted to the facility on 7/29/09 with the latest return on 10/18/11, and diagnosis which included atrial fibrillation (rapid, irregular heart beat).

The physician ordered revealed the following medications with (BBW) black box warnings: Coumadin 5 mg (milligrams) by mouth daily, on 4/9/13.

According to federal drug administration website, Coumadin had a black box warning of: "Bleeding risk. Coumadin can cause major or fatal bleeding.

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F 428	Continued From page 78 Perform regular monitoring of labs in all treated patients. Drugs, dietary changes, and other factors affect INR (International Normalized Ratio) levels achieved with Coumadin therapy." Review of the plan of care, revealed that the plan failed to include the BBW specific to the adverse consequences for the Coumadin. Review of the nurses note, dated 6/26/13 at 1:46 pm, revealed "...Continue Coumadin at 5 mg daily and recheck INR in 2 weeks." Nurses note, dated 7/17/13 at 5:19 pm, "Continue Coumadin at 5 mg. Recheck in 2 weeks per doctor office." After review of the laboratory results, there was no lab obtained on or around July 9, 2013, when the lab was ordered to have been drawn. It was, however, drawn on 7/17/13. The order received was to recheck the lab in 2 weeks and as of 8/19/13 it had not yet been drawn until it was brought to the administrative nursing staff attention. Observation on 8/14/13 at 7:30 am, revealed the resident sitting in electric wheelchair at the dining room table, feeding self breakfast and with a light purple bruise fading to right forearm. Interview on 8/15/13 at 10:00 am, administrative nursing staff B reported, "We got our BBW out of the Lexicomp book." On 8/19/13 at 2:40 pm, administrative nursing staff B reported, "The last PT/INR (Prothrombin time) was obtained on 7/17/13. Yes, it was done after it should have been. We will be getting it done this week."	F 428		

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On 8/19/13 at 3:00 pm, administrative nursing staff B reported, "When a lab is missed, the physician is notified. We will get a new order for the lab."

On 8/21/13 at 3:17 pm, consultant staff J, when asked about PT (Prothrombin time)/INR monitoring, replied, "I look at the results normally." When asked how BBWs are monitored, staff J replied, "I usually check those on a quarterly basis."

The policy and procedure for medication-boxed warnings, with no date, revealed, "...It is the policy of [the facility] that all medications including boxed warnings will have the appropriate literature available to healthcare staff located with the residents MAR (Medication Administration Record) and also in the residents plan of care...All resident medications referenced in Lexicomp's Geriatric Dosage Handbook 2012, 17 th Edition..."

The policy and procedure for laboratory test request, with no date, revealed, "...The Director of Nursing/designee will be responsible for ensuring that (1) all requested laboratory tests are obtained and the results are reported to the physician in a timely manner..."

The facility consulting staff failed to identify the facility's lack of monitoring for the adverse consequences associated with the black box warning for the administration of Coumadin to this resident and failed to appropriately obtain laboratory tests to ensure that appropriate levels were achieved, and the medication not unnecessary.

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- The electronic medical record for resident #19 revealed the resident admitted to the facility on 2/13/11 with the latest return of 5/23/12, and diagnoses of migraine and chronic (persisting for a long period, often for the remainder of a person ' s lifetime) pain.

Physician's orders dated 7/1/12, revealed the following medications with (BBW) black box warnings: Duragesic/Fentanyl 25 micrograms per hour one transdermal every 3 days for chronic pain.

According to federal drug administration website, fentanyl transdermal patch/Duragesic patch had a black box warning of: "abuse potential, respiratory depression and death."

Review of the plan of care, revealed that the plan failed to include the BBW specific to the adverse consequences for the Fentanyl.

Observation on 8/13/13 at 4:53 pm, revealed the resident wheeling self in wheelchair, heading to the dining room for supper with no signs of pain noted.

Interview on 8/15/13 at 10:00 am, administrative nursing staff B reported, "We got our BBW out of the Lexicomp book."

On 8/21/13 at 3:17 pm, consultant staff J, when asked how BBWs are monitored, staff J replied, "I usually check those on a quarterly basis."

The policy and procedure for medication-boxed warnings, with no date, revealed, "...It is the policy of [the facility] that all medications including boxed warnings will have the appropriate

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F 428	Continued From page 81 literature available to healthcare staff located with the residents MAR [Medication Administration Record] and also in the residents plan of care...All resident medications referenced in Lexicomp's Geriatric Dosage Handbook 2012, 17 th Edition..." The facility consulting staff failed to identify the facility's lack of monitoring the adverse consequences associated with the black box warning for the administration of Fentanyl/Duragesic to this resident.	F 428		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions	F 441		9/20/13

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from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
The facility reported a census of 31 residents. Based on observation, and interview, the facility failed to maintain an Infection Control program designed to provide a safe, sanitary, and comfortable environment and prevent the development and transmission of infections during medication administration, the laundry and in 1 of 2 medication room snack refrigerators, for the residents.

Findings included:

- Observation, on 8/12/13 at 8:51 AM,revealed laundry/housekeeping staff N delivered laundry, from an uncovered cart, throughout the resident hallways, and into the individual resident rooms.

Observation on 8/13/13 at 8:21 AM, revealed the linen cart with resident clothing on hangers transported through the hallway with the cover thrown up on the top and continued in this manner to deliver the clothes into rooms in the middle hallway on the east side of the facility. At

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8:35 AM, laundry/housekeeping staff N delivered clothing in this manner on the east end and at 8:45 AM, on the west end of the middle hallway. During this process staff N visited with Maintenance staff G, while delivering clothing. Staff G failed to identify the problem and failed to instruct staff N of the need to place the clean clothing cover back down over the residents' clean clothing.

Observation, on 8/12/13 at 8:51 AM, revealed laundry/housekeeping staff N continued to deliver the clean laundry, from an uncovered cart, in the hallways, to resident rooms.

Observation, on 8/13/13 at 8:40 AM, revealed laundry/housekeeping staff N again delivered laundry, from an uncovered cart, in the hallways, to the resident rooms.

On 8/14/13 at 8:12 AM, laundry staff N delivered clothes to the residents from the laundry cart, with the front cover up over the top of the cart and hanging at the back. Staff N pushed the cart down the hallway this way and left the cart uncovered in this manner when clothing is being delivered into the resident rooms. This is on the west side of the middle hallway. At 8:19 AM, staff N moved the uncovered laundry cart of clean clothing to the east side of the middle hallway.

On 8/14/13 at 8:22 AM, laundry/housekeeping staff N reported, "I keep the cart covered until I come in the building. Then I uncover the laundry cart while delivering."

On 8/14/13 at 8:25 AM, laundry staff N pushed the linen cart back through the middle hallway towards the west side. It was pushed, uncovered

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with clean clothing directly past administrative nursing staff B, who did not instruct staff N to cover the clothing or the need to cover the clean clothing.

On 8/15/13 at 1:00 PM, Housekeeping/Maintenance/Laundry staff G reported, "The cover on the laundry cart should be down when the staff are delivering the laundry."

The facility failed to ensure staff handled clean linens in a sanitary manner to prevent the spread of infection to the residents.

- Observation, on 8/13/13 at 8:30 AM, revealed licensed staff I brought IV (intravenous) medication, with tubing into resident #15's room, and placed it directly on the bedside table. Staff I proceeded to take the old IV medications from the infusion pump, and failed to wash their hands. Staff I flushed the central line with normal saline, without handwashing or gloves on, with contaminated hands and then placed the new tubing in the infusion pump. Staff I then cleansed the resident's central line cap with an alcohol pad, without handwashing or gloves on and with contaminated hands. Staff I proceeded to connect the tubing from the infusion pump to the central line, without handwashing or gloves on and with contaminated hands, to administer the medication into the resident's central line.

On 8/15/13 9:30 AM, administrative nursing staff B reported, "The staff should wash hands and wear gloves when they are hanging IV medication and dealing with a central line."

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F 441	Continued From page 85 The facility failed to ensure staff handled/care of a central line, using a clean technique, to prevent the development or spread of infections. - Observation during initial tour of the facility on 8/12/13 at 9:48 AM, revealed the east Medication Room snack refrigerator held resident food items (thickened water boxes and Glucerna boxes) as well as a 24 hour resident urine collection container, with visible urine in it, on the bottom shelf. On 8/12/13 at 10:20 AM, direct care staff K stated, "This is the nourishment fridge. It is for resident snacks." On 8/13/13 at 1:24 PM, administrative nursing staff B stated, "The fridge in the med room that does not have insulin in it, is a snack fridge to keep food in for the residents. There should not be anything other than food in that fridge." On 8/13/13 at 4:25 PM, administrative nursing staff B stated, "[Facility] policy for urine collection container storage is that it would be stored in a cooler in the resident room or bathroom during the collection timeframe. Then that cooler would be moved to the medication room, with the urine in it for storage, until it can be transported out of the facility. We don't have a written policy on that, but staff should be aware of that process." The facility failed to ensure an infection control program to prevent the development or the spread of infection to the residents of the facility.	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABL	F 465		9/20/13

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F 465	Continued From page 86 E ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: The facility reported a census of 31 residents. Based on observation and staff interview, the facility failed to provide a safe, functional, sanitary, and comfortable environment, in the kitchen area, for residents and staff. Findings included: - The kitchen environmental tour on 8/14/13 at 2:20 pm revealed: a) The metal back splash behind the dishwashing station has an area in a "V" shape, measuring approximately 6 inches, that has rough edges and a white substance all around the area, deteriorating the metal. b) The wall behind the dishwashing station contained multiple open voids of various sizes so it can not be sanitized and also contained multiple dried splatters across the wall. c) The flooring in front of the dishwasher, with 20 tiles affected, contain multiple cracks throughout the tiles. On 8/14/13 at 2:37 pm, dietary staff F reported, "The silverware cleaner has dripped on the back splash for so long, that it has ate through the metal and it does need replaced." Staff also	F 465		

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F 465	Continued From page 87 reported, "We have had problems with water coming in on the floor and it has affected the tiles in here." The facility filed to provide a safe, functional, sanitary, and comfortable environment, in the kitchen area, for residents and staff.	F 465		
F 467 SS=B	483.70(h)(2) ADEQUATE OUTSIDE VENTILATION-WINDOW/MECHANIC The facility must have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two. This REQUIREMENT is not met as evidenced by: The facility identified a census of 31 residents. Based on observation and interview, the facility failed to ensure adequate outside ventilation in one beauty shop room, for the residents of the facility. Findings included: - During environmental tour of the facility, on 8/15/13 at 10:30 AM, the beauty shop lacked a ventilation system. On 8/15/13 at 10:30 AM, maintenance staff G stated being unaware of the need for a ventilation system in the beauty shop. The facility failed to assure that the beauty shop provided adequate outside ventilation.	F 467		9/20/13
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each	F 514		9/20/13

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resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:
The facility had a census of 31 residents, with 14 residents reviewed. Based on interview and record review, the facility failed to maintain complete and accurate clinical records for 1 (#6) sampled resident.

Findings included:

- The electronic face sheet, revealed resident #6, readmitted to the facility on 12/3/08, with the following diagnoses; multiple sclerosis (progressive disease of the nerve fibers of the brain and spinal cord), glaucoma (an abnormal condition of elevated pressure within an eye caused by obstruction to the outflow), osteoporosis (disorder characterized by abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk), anxiety disorder (a mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, melancholy, dejection, worthlessness, emptiness and hopelessness),

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and muscle spasm.

Review of the resident's electronic clinical record, revealed the record lacked documentation of the resident's accidents.
1.)The facility provided paper form, "Unusual Occurrence Record", dated 7/30/13, documented the following; "Resident: Alert and oriented, unattended fall,bruise. At 8:30 AM, CNA [certified nurses assistance] called this RN [registered nurse] to the bathroom and stated resident was yelling out 'help'. Upon entering, resident was sitting on the floor in front of toilet. Resident stated [he/she] was 'trying' to get to the toilet but didn't make it. Denies pain and denies hitting [his/her head]. Bruise noted to right mid back, 2.5 cm [centimeters] by 4 cm. Bruise to right arm, below elbow, 2.5 cm by 1 cm. New intervention: Placed back into manual wheelchair, due to complication of transferring from scooter." The staff continued to document vital signs on the resident every 12 hours through 8/1/13 for 6 PM-6 AM.

2.) The facility provided paper form, "Unusual Occurrence Record", dated 8/2/13 at 2:00 PM, documented the following: "Smoke Room. Resident alert, injury of hematoma [a collection of blood trapped in the tissues of the skin or in an organ, resulting from trauma]. Resident leaned over in wheelchair to pick up unlit cigarette and fell to the floor. A 3 cm round hematoma over forehead. Ice pack applied to forehead prn [as needed] given for complained of pain.
New intervention: Staff to hold cigarettes until they are there to supervise." The staff continued to document vital signs and bruising on resident every 12 hours through 8/4/13 for 6 PM-6 AM..
On 8/14/13, at 4:00 PM, administrative nursing

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staff C reported, "When a resident has a fall, the staff will do a Unusual Occurrence Form. We do not chart on the computer if we use this form."

On 8/15/13,at 10:00 AM, administrative staff B reported, "We have paper records of the unusual occurrences for things like falls and bruises. The information from the paper unusual occurrence forms are to go into the computerized record, but we are changing computer programs so they are probably not getting put in the resident records now. I was told to throw them away, but I kept them myself, in case there of an issue." Staff B verified the facility residents clinical records in the electronic system are not complete with the information from these "Unusual Occurrences Form."

On 8/15/13 at 3:50 PM, administrative nursing staff Y reported, "We are changing computer systems, so some of the resident information is on paper and the other resident information is in the computer. I think we are going to have to make a chart for each resident, so the clinical record is available."

The facility failed to ensure a complete accurate clinical record for each of the residents that experienced accidents or bruises, including this resident.